

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-309	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/05/2019
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NAME OF PROVIDER OR SUPPLIER INDEPENDENT LIVING AT RANSOM RD	STREET ADDRESS, CITY, STATE, ZIP CODE 355 RANSOM ROAD WINSTON SALEM, NC 27106
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	<p>INITIAL COMMENTS</p> <p>A complaint and follow-up survey was completed on 4/5/19. The complaint was unsubstantiated (Intake ID NC00149886 & NC00149983). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600b Supervised Living for Minors with Developmental Disabilities.</p>	V 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____